Williamson County Benefits Department
Spousal Insurance Information Form

This form is required to be completed in full and accompany the medical enrollment form when an employee is enrolling a spouse with an enrollment effective date January 2, 2007 or later. A spouse will not be eligible or be enrolled in the medical plan until this form is completed and returned to the Williamson County Benefits Department with the medical enrollment form.

Section #1: Employee Information
Employee Name: _____ Employee SS#: _____

Spouse Name: _____ Spouse SS#: _____

Please choose appropriate option;

- **1. My spouse is not actively working.** If the spouse is not currently working and the employee elects to cover the spouse under the Williamson County Medical Benefits Program, only the designated contribution will apply. Skip to Section 3, page 2 of this document for completion.

- **2. My spouse is working and has elected coverage through his/her employer as primary coverage and is enrolling in the Williamson County Medical Program as secondary coverage.** If the spouse is enrolled under his/her employer's medical plan as primary coverage and the Williamson County Medical Benefits Plan as secondary coverage, the employee will not be charged the additional surcharge. Page 2, Section 2 and 3 required completion.

- **3. My spouse is working and has declined coverage through his/her employer and is enrolling in the Williamson County Medical Program as primary coverage.** If the spouse declines health coverage through his/her employer and elects coverage under the Williamson County Medical Benefits Program, the employee will be charged the designated contribution set by Williamson County for the number of dependents enrolled plus an additional $100.00 monthly surcharge for the enrollment of the spouse. Page 2, Section 2 and 3 required completion.

- **4. My spouse is working and does not have medical coverage available through his/her employer and is enrolling in the Williamson County medical program as primary coverage.** If the spouse does not have coverage available through his/her employer and the employee elects to cover the spouse under the Williamson County Medical Benefits Program, only the designated contribution will apply. This option includes spouses that are self-employed. Page 2, Section 2 and 3 required completion.

Employee Name: _____
Coverage Verification for (Spouse Name): *_____

Section #2:
This section must be completed in full by the **Employer** of the above named spouse enrolling in the Williamson County Medical Program if 2, 3 or 4 were selected in Section 1 of this document.

Name of Employer and address: _____
_____
_____

1. Does your Company offer medical benefits to employees? YES____ NO____
   If No: why does your Company not offer benefits? _____

2. Is the above named *spouse eligible for benefits? YES ____ NO____

3. Is the above named *spouse enrolled in your Company's medical benefit program? YES___ NO____
   If Yes: Name of insurance plan_____
   Group # of insurance plan_____
   Effective Date of coverage_____
   If No: Explain why above named *spouse is not enrolled in his Employer medical plan:
   _____

4. Will the above named *spouse, if not enrolled currently, be eligible to enroll in the medical plan in the future? YES____ NO_____ If so when? _____

5. Print name of person completing form _____
   Job Title: _____ Phone number: _____

Signature of person completing form on behalf of the employer:
_____ Date: _____

Verification of Self Employment:
If *spouse is self employed please provide the following:
Name of Company, Address and phone number:
_____
_____
_____
Are medical benefits offered to any Employees of this organization? YES _____ NO _____
If No, Why_____
If Yes, please answer #3 above.
Do you own this company? YES _____ NO _____

Section #3: Employee Signature

By signing below, I represent and warrant that all information provided is accurate, current and complete to the best of my knowledge. Falsification of information regarding the spouse's available coverage will result in, at a minimum, the additional premium surcharge being assessed retro-actively back to the date of the spouse's enrollment in the medical benefits program and/or termination from the medical benefits program. In addition, willful provision of false information may result in disciplinary action against the employee up to and including termination.

I also understand that if the status of medical coverage for my spouse changes, it is my responsibility to notify the Williamson County Benefits Department within 30 days of the change. If the Spousal Surcharge is to be discontinued due to a change, there will be no refund of the previous Spousal Surcharge deduction if the Williamson County Benefits Department is not notified within 30 days of the change.

Employee Signature: _____
Date: _____